VSH Futures
Care Management Work Group
Meeting Minutes
August 25, 2006

Participants: Isabelle DesJardins, UVM/FAHC: Stan Baker, HCHS/DS; Peter Tomashow, CVH; Sandy Steingard, HCHS; Nick Emlen, VT Council; Michael Hartman, WCMH; Jeff Rothenberg, CMC; Richard Lanza, LCMH; Peter Albert, Retreat Health Care; Bob Jimmerson, CSAC; Bob Pierattini, UVM/FAHC.

Staff: Cindy Thomas, Patti Barlow, Bill McMains, Judy Rosenstreich, Beth Tanzman, VDH

Miscellaneous

Stan Baker requested that Pat Frawley (a leader in the DS services system) to join group. He also offered to develop sub-group focusing on Developmental Services to develop a protocol or statement on DS system fit especially discharge planning from acute care to DS system. Isabelle Desjardins, Pat Frawley, Stan Baker to form a sub-workgroup.

Change of Level of Care Criteria

Goal for the meeting today is to accept, reject or alter the Change of Level of Care Criteria.

Discussion:

These are not so much admission guidelines as a filter through which to evaluate the performance of the system. Sandy suggests incorporating this algorithm in the dispute resolution process to identify where the disagreements are. Isabelle stated it is fair to design a system based on what is best for the client, however, we need to do this within resources. Richard recommends that we pilot or field test this before we fully use.

Peter Albert: asked are these descriptive or guidelines? Bill McMains offered as a general principle anything we develop should be considered guidelines. Clinical rules are guidelines and are not designed to over ride individual clinical judgment. Sandy also offered that this document may be helpful for training and orientation at it is difficult it is to learn the nuances of the system and it could assist to think more clearly

Peter Tomashow observed that the first question, “adequate safety yes/no” is not simple to answer. Peter Albert stated that from the private commercial side we all know how guidelines end up being used: in a review situation the guidelines often become prescriptive. He agreed that this is a:

- Good tool for developing data or where the system is failing
- Among collaborating partners; this will help too.

Nick asked how would this tool be received by hospitals? Peter T. said they would likely not be very interested in this and doesn't see how this helps because often differences of opinion are philosophical. It is interesting for data collection and helps the role that each institution plays however; each program would need its own criteria in addition to this.

Bob observed that there is a risk or downside – i.e. who determines what adequate safety is? It's not as useful without clear explanation of what safety is and there is a risk in assuming that these principles are understood or that there is a collective understanding of them.

Jeff offered that he likes itt, if the standardization is helpful. Care Management system only works as well as its resources, e.g. if there is enough housing then discharging is much easier.

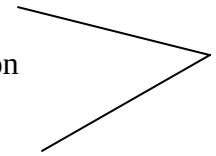
Bill McMains asked whether this would be useful to the current care management team. Cindy stated that it could be very useful to more clearly identify where the blocks or difficulties lie in complex situations. We discussed the care management team piloting use of the tool by:

- Track 50 consecutive admissions
- Count the number of excess inpatient days resulting from certain barriers, e.g. really qualify for an economic argument.

Alternatively, Bob suggested that staff of the team could sit in on rounds for 30 consecutive days then going to the next hospital repeating the same procedure.

Two combined issues: use of the instrument pilot; resource gap identification

- Training
- Conflict resolution
- QI/QM



3 uses of the tool in the discussion

Michael: Can the system agree to a single organization schematic to link common language, common expectations. Is the system ready to commit to a single set of rules? System needs this guidance system. Today 53 people at VSH – not all need to be there and we have empty beds at DHS and crisis bed programs – so it's not working!
How do we make the whole system work not simply hold anyone competent, accountable or responsible for a failure?

Stan: Is diagnostic or admission criteria assumed in this chart – e.g. are there separate criteria? Bob replied yes, admission criteria are implied in balanced intensity of treatment.

Peter A: This is a great tool. Best practice. Greatest in weakest aspect of our field is individual clinical judgment. With data based on this tool it could generate best practices based on experience. Pilot it so that we understand how.

Jeff: Are we part of a single-linked system?

Our goal is to be a linked system

Tension between a linked system and individual clinical judgment, e.g. the concept of assessing safety is a cultural dynamic and it shifts.

Framework: Respect individual judgment and yet –

- Work collectively in an organized manner to make sure the system uses scarce resources well and clients get the care they need.

Don't we need to have an agreement in the abstract and principles?

Sandy: We do need some kind of a group to take on in a more systematic way the very difficult borderline patients who are frequently admitted to hospitals. What seems to work is a lot of coordinated clinical discussion about treatment approaches with all parts of the system that these clients touch.

Michael: If we could come to shared clinical agreement among those cases the system would work well. It would be better if the whole system would agree to each handle of these "hot potatoes" rather than leave it to the hands of VSH, Home Intervention, and sometimes the Retreat. This leaves VSH in the most toxic, unsafe situation. What is discouraging is when a hospital won't even try to treat someone who meets criteria for admission. Peter offered that the idea of care management plans on a state-wide basis for the most difficult, chronic patients is terrific. The discussion of why any one hospital will not admit is only one part of the equation.

An agreed upon treatment approach held system wide works really well and in fact help the system share risk

Summary:

This tool is valuable within limits. We do have a workgroup looking at admission criteria and tests should be embedded in the "balanced intensity of treatment." A central organization for treatment planning for an identifiable group of clients that is readily available for any provider in the system who will have contact with the client would be very helpful.

There is a rudimentary system for this kind of system in place but it needs more development.

For next or future meeting – we should formally adapt the principles that of the care guide client moving through the system of care.

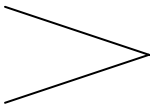
Outline of overall Care Management structure

Review Nick's list
Review of the allocation for care management and its purpose
Need a path to develop the information system

- Measurement and quality date
- Will include private medical clinical data

What about linking with the Blueprint project and its medical records work?
We need a point person with it expertise is needed

- Are there other backbones we connect into
- What is their timeframe for implementation
- Allowable exchange of information



HIPPA

Focus IT issue on the statewide treatment plans